FAMILY LIVING INSTITUTE

1307 Jamestown Rd. Suite 202
Williamsburg VA, 23185

Phone: 757-229-7927
Fax: 757-253-8891

REQUEST FOR RECORDS

Patient Name: _____ Date of Birth: _____

(Last) (First) (Middle)

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Name of Provider: _____

Which of the following are you requesting? (Check all that apply)

☐ Healthcare/Treatment Records ☐ Billing Information ☐ Other: _____

Please describe the information you wish to obtain including date(s) of the requested information:

_____

_____

If you would like a copy of these records, you will need to pay for copying and postage as allowed by law. Payment will be required prior to the copy being made and sent to you. If you do not wish to pay for these records, you may make an appointment to look at these records at our office. Please note that we need at least two (2) business days to review your request. All processing of client requests shall be completed within fifteen (15) days of receipt.

Please check one of the following:

☐ I would like my records sent to be at the address listed above

☐ I would like to make an appointment to review my records at this office.

_____

Signature of Client or Legal Guardian

_____

Date:

Revised 10/23/2017